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ABSTRACT

This paper defines the eating disorders of anorexia nervosa, bulimia, and bulimia nervosa, a bulimic subtype of anorexia nervosa. The diagnosis of these disorders is discussed and similarities and differences among the three disorders are reviewed. Etiological factors are considered and current trends in treatment of anorexia nervosa, bulimia, and bulimia nervosa are examined. A multidimensional group therapy approach for individuals with these eating disorders is proposed. Included are a general description of the proposed treatment, a discussion of intake and screening procedures, and a list of group objectives and goals. The three stages of development often experienced by successful groups are examined: (1) testing-dependence/orientation to the task stage; (2) intragroup conflict/emotional response to task demands stage; and (3) development of group cohesion/open exchange of relevant interpretations stage. The therapist's role at each stage is described and suggested interventions are given. The paper concludes that the approach presented has not yet been used in a clinical setting nor have empirical tests of its effectiveness been conducted. A three-page reference list concludes the document. (NB)

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The Treatment of Anorexia Nervosa and Bulimia: A Multidimensional Group Approach

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Abstract

In this article, the diagnosis and nature of anorexia nervosa and bulimia is discussed, current trends in treatment are described, and a group treatment plan is proposed.

The Treatment of Anorexia Nervosa and Bulimia: A Multidimensional Group Approach

During the past decade, professional interest in understanding and treating anorexia nervosa and bulimia has greatly increased. This interest has been stimulated by the fact that the reported incidence of these disorders is rising (Bemis, 1978; Leon & Phelan, in press; Polivy & Herman, 1985) and because the disorders have serious medical and social consequences (Anderson, 1983). In this article, the diagnosis of anorexia nervosa and bulimia is discussed, the nature of these disorders and current trends in treatment are briefly described, and a multidimensional group treatment plan is proposed.

Description and Diagnosis

There is considerable confusion evident in the literature concerning the diagnosis of anorexia nervosa and bulimia (Casper, 1983; Holmgren et al., 1983; Mitchell & Pyle, 1982). The main source of the confusion seems to be due to inadequate diagnostic descriptions in DSM-III (Mitchell & Pyle, 1982) which fail to provide a diagnostic category for patients who exhibit symtoms of both anorexia nervosa and bulimia. Although the diagnostic issues are not fully resolved, the current trend seems to be to consider patients exhibiting symptoms of both anorexia nervosa and bulimia as a subtype or subgroup of anorexia nervosa. Patients in this subgroup are referred to as bulimic subtypes or as bulimic anorexics (Leon & Phelan, in press; Russell, 1979). The diagnostic criteria for anorexia nervosa, bulimia, and bulimia nervosa (the bulimic subtype of

anorexia nervosa) will now be described; however, it should be kept in mind that the differential diagnosis of these disorders is still evolving and the criteria may undergo further revisions.

Anorexia nervosa is a disorder which is characterized by a fear of fatness and self-induced starvation. According to DSM-III (1980), the essential features of anorexia nervosa are:

> intense fear of becoming obese, disturbance of body image, significant weight loss, refusal to maintain a minimal normal body weight, and amenorrhea (in females) . . . Individuals with this disorder say they 'feel fat' when they are of normal weight or even emaciated. They are preoccupied with their body size and often gaze at themselves in a mirror. At least 25% of their original body weight is lost, and a minimal normal weight for age and height is not maintained. (p. 67-68)

When weight loss becomes profound in anorexia nervosa, a number of harmful physical problems, and even death from severe starvation can result (Anderson, 1983). According to Bemis (1978), mortality rate statistics for anorexia nervosa range from 3-4% up to 25%.

Bulimia is characterized by a pattern of episodic binge eating (Mitchell & Pyle, 1982). According to DSM-III (1980), the essential features of bulimia are:

> episodic binge eating accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop eating voluntarily, and depressed mood and self-depreciating thoughts following the eating binges . . . Individuals with bulimia usually exhibit great concern about their weight and make repeated attempts

> to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these individuals feel that their life is dominated by conflicts about eating . . . bulimic episodes are not due to Anorexia Nervosa . . . (p. 69-71)

As in anorexia nervosa, the physical consequences of bulimia can be harmful and although the mortality rate in bulimia hasn't been ascertained accurately, death due to hypokalemia or suicide can occur (Anderson, 1983; Bemis, 1978).

Bulimia nervosa, the bulimic subtype of anorexia nervosa, shares the characteristics of anorexia nervosa and bulimia. Bulimic subtypes meet the diagnostic criteria for anorexia nervosa but are differentiated from those with the restrictor subtype of anorexia nervosa by their use of vomiting to achieve and/or maintain their low weight (Leon & Phelan, in press; Russell, 1979). The main diagnostic criteria used to differentiate between the bulimic subtype of anorexia nervosa and bulimia is body weight—bulimic subtypes meet the DSM-III criteria (for anorexics) of 25% loss of original body weight while patients diagnosed as having bulimia do not (G.R. Leon, personal communication, February 5, 1985).

Common Features of the Disorders

It appears that the central pathological symptom patients with these disorders have in common is a conflict between "anorectic strivings" and "bulimic impulses" (Holmgren et al., 1983, p. 11). Holmgren et al. (1983, pp. 10-11) describe anorectic strivings as "an intense fear of gaining weight, a fear completely unrelated to the actual weight level,

and a permanent pursuit of lower weight" and the bulimic strivings as a "permanent preoccupation with thoughts and actions concerning food and eating, and more or less frequent urges to gorge without restraints" In addition to this shared central conflict, there is evidence that the three types of patients have in common personality features such as "marked symptomatology, depressive traits, alienation, hostile feelings towards men and a stereotypical, conventional view of femininity" (Norman & Herzog, 1983, p. 50). It also appears fairly common during the course of these disorders for anorexia nervosa to develop into bulimia nervosa or visa versa or for bulimia to develop into bulimia nervosa or anorexia nervosa (Anderson, 1983; Holmgren et al., 1983). Thus, it is clear that anorexia nervosa, bulimia, and bulimia nervosa have a number of features in common and probably should, as Anderson (1983) has suggested, be seen as overlapping disorders. It is too soon to know whether Holgrem et al.'s (1983) recommendation to view patients in the three disorder groups as one group will prove useful and be adopted.

Distinctive Features of the Disorders

In addition to the differences in diagnostic criteria described earlier, other personality and behavioral differences between patients with these disorders have been described. These reported differences should be viewed somewhat tentatively, however, as there are few empirical studies comparing the three groups and the confusion in the literature about differential diagnosis has made it unclear at times as to which group was being described.

Keeping these uncertainties in mind, it appears that the restrictor

subtype of anorexia nervosa differs from the bulimic subtype and from bulimics (without anorexia) in that restrictors tend to be more obsessive, perfectionistic, and introverted than bulimic subtypes and bulimics. Restrictors usually deny their hunger and take pride in their eating behavior whereas bulimic subtypes and bulimics admit their hunger more readily and tend to be more ashamed of their eating behavior. Restrictors tend to be described as model children while bulimic subtypes and bulimics also tend to be more depressed and anxious and to come from a less stable family environment than restrictor subtypes (Anderson, 1983; Leon & Phelan, in press; Mitchell & Pyle, 1982; Norman & Herzog, 1983).

Identifying possible personality and behavioral differences between bulimics and bulimic subtypes is even more tenuous because the problems mentioned earlier concerning lack of research and confusion about diagnosis have muddied the waters even more for these two groups. Norman and Herzog's (1983) study which compares MMPI profiles of bulimics and bulimic subtypes is a beginning towards helping us understand the differences between these two disorders, however, it identifies similiarities between the two groups for the most part and provides little clear evidence concerning differences.

Etiological Factors

There has been considerable speculation concerning what factors cause and maintain anorexia nervosa, bulimia, and bulimia nervosa. Psychodynamic, familial, sociocultural, behavioral, cognitive, genetic, and physiological concepts of origin have all been proposed (see Bemis, 1978; Garner & Bemis, 1982; Leon & Phelan, in press; Mitchell & Pyle, 1982; Polivy & Herman, 1985;

Schwartz, Thompson, & Johnson, 1982 for discussions and reviews of the evidence supporting the various theories of origin). Most researchers and theorists now seem to favor multifactorial explanations of causation, acknowledging that psychological, physiological, and sociological factors all may contribute to the onset and maintanence of these disorders (e.g., Leon & Phelan, in press; Schwartz et al., 1982).

Trends in Treatment

A variety of treatment approaches for anorexia nervosa and bulimia have been utilized (Bemis, 1978). Psychodynamic, family interactional, behavioral, and medical approaches have been used perhaps the most frequently (Bemis, 1978). According to Garner and Bemis (1982), however, these traditional approaches have met with rather limited success. Although long-term outcome studies indicate that between one-third to one-half of patients treated by traditional approaches achieve a satisfactory outcome in terms of weight status, when other variables, such as psychiatric disturbances, abnormal eating patterns, preoccupation with weight, and body image disturbances are assessed, the outcome appears considerably less positive (Garner & Bemis, 1982).

Because traditional approaches have met with limited success, alternative methods of treating anorexia nervosa and bulimia are being proposed. For example, Levenkron (1982) has recently described a "nurturant-authoritative" psychotherapeutic approach (p. 20). Garner and Bemis (1982) have proposed a cognitive-behavioral approach, Garner, Garfinkel, and Bemis (1982) described a "multidimensional psychotherapy" (p. 3), and Anderson (1983) has outlined what he feels is a comprehensive

"team approach" (p. 9). A common feature of the new treatment approaches is that they are more eclectic in nature than the traditional approaches. The new approaches are based on the assumption that multiple factors contribute to the development of anorexia and bulimia and these approaches attempt to be more comprehensive in the therapeutic methods they employ.

A Proposed Multidimensional Group Therapy Approach

Leon and Phelan (in press) recently recommended the more frequent practice of treating patients with anorexia nervosa and bulimia nervosa in semi-structured group settings in the community rather than in hospital settings. They feel that outpatient group treatment approaches will be less costly and the "behavioral and attitudinal gains established outside of the hospital might be more likely to be maintained over an extended period of time" (Leon & Phelan, in press, p. 45).

A multidimensional group counseling approach for the treatment of anorexia nervosa, bulimia nervosa, and bulimia will now be described with the hope that it will provide some useful clinical strategies for group therapists working with clients with these disorders in outpatient settings. This approach is based on the assumption, as are the new individual approaches mentioned above, that these disorders are caused by multiple factors and that the wide range of treatment modalities used in a multidimensional approach will be more effective than more narrow, traditional approaches.

General Description

Because the treatment of patients with anorexia nervosa and bulimia may require several years (Garner, Garfinkel, & Bemis, 1982), an open-ended therapy group which meets twice a week for 90 minutes is recommended (Yalom, 1975). The flexibility an open-ended group offers will allow the therapist to more effectively meet the needs of clients who vary in degree of severity of their disorder. Some clients may need only 3 months in the group and others may need 3 years. An open-ended group can accomodate such differences.

The group may be heterogeneous—that is, clients with anorexia nervosa, bulimia nervosa, and bulimia can be in the same group. As has been discussed earlier, the issues and treatment strategies for clients with these disorders are similiar and at the present time there seems to be no compelling reason not to groups these clients together for treatment (e.g., Holmgren et al., 1983).

Intake and Screening

All clients should participate in an intake/screening interview. In general, the purpose of the intake interview is to build trust, give information about the group goals and operation, establish and clarify client expectation, assess client readiness and other characteristics, and to begin client goal clarification (Anderson, 1984). Another purpose of the intake interview is to explain to the group members that they are required, if they wish to participate in the group, to have a medical examination by a collaborating physician. If the client has been referred by a physician, he or she may already have had a medical, however, the

periodic check-ups should still be required. The purpose of the medical examination and check-ups—to monitor and safeguard the physical health of the client—should be explained in the intake interview. It should also be mentioned that the physician may recommend inpatient treatment if the client has an extremely low weight or severe metabolic abnormalities (Anderson, 1983).

Anderson (1983) believes that therapists should concern themselves with both the physical and psychological well-being of anorexic and bulimic clients. Not only can anorexia and bulimia be physically harmful and even dangerous, reason enough for therapists to concern themselves with their clients physical well-being, but it appears that psychological treatment is much less effective when clients are emaciated (Anderson, 1983; Bruch, 1978). Therefore, a balance "between changing the eating and weight symptoms themselves and attending to the underlying psychological conflicts" should be maintained (Anderson, 1983, p. 15).

Group Goals and Objectives

The metagoals for the group are as follows:

1. Clients will understand the physical consequences of anorexia nervosa and bulimia and in consultation with a physician, will monitor and take care of their physical well-being.
2. Clients will recognize and work through the psychological and emotional problems which are related to their abnormal eating control behaviors.
3. Clients will overcome their abnormal eating control behaviors. They will no longer engage in self-starvation, binging, vomiting, or the use of cathartics or diuretics.

In addition to the metagoals listed above, the group process goals are:

1. A climate of trust, acceptance, and belongingness will be established and group norms will be created and followed (Corey, 1981).
2. Anxiety, resistance, and conflict will be worked through constructively and clients will reconcile their goals with the metagoals and group norms (Hanson, Warner, & Smith, 1980).
3. Group cohesion will develop and therapeutic work will occur (Corey, 1981).

Group Development and Process

There are three stages of development successful groups tend to experience. The first stage of development has been referred to as the testing-dependence/orientation to the task stage (Tuckman, 1965). During this stage, clients are dependent on the therapist because of the newness of the situation. The therapist needs to orient the clients to the group norms and tasks. The clients will test each other and the therapist to further discover and establish the group norms (Rosenfield, 1973).

The therapist should assume a directive role during this stage of the group. It is during this stage that clients need to gain an understanding of anorexia nervosa and bulimia and take steps to monitor and maintain their physical well-being. Also, during this stage the first group process goal needs to be achieved—it is important that a climate of trust, acceptance, and belongingness be established (Corey, 1981). Some specific interventions that the therapist can make during this stage to

achieve these goals are:

1. During the first session, the therapist should review the group goals, norms, and operation and lead the group in a warm-up, getting acquainted activity. In the first session, and all subsequent sessions, the therapist needs to model skills and qualities such as empathic listening, warmth, respect, unconditional positive regard, and genuinness (Gazda, 1978).
2. The therapist needs to educate clients about anorexia nervosa and bulimia. According to Garner and Bemis (1982), providing clients with information about the symptoms of these disorders can help clients understand that some of the symptoms they are experiencing (e.g., short attention span, dysphoria) are due to malnutrition and not because of internal deficiencies. Information about the risks and course of the disorders "implant a healthy concern about the hazards" of anorexia and bulimia and can weaken the clients "treasured misconception that their extraordinary thinness is an expression of specialness or superiority" (Garner & Bemis, 1982, p. 133).

Stage Two

The second stage of group development has been referred to as the intragroup conflict/emotional response to task demands stage (Tuckman, 1965). During this stage, clients attempt to express their individuality and resist group structure by displaying acts of hostility toward each other and the therapist. The clients also react emotionally to the demands placed on them by the task and attempt to reconcile their personal orientation with the group orientation (Rosenfeld, 1973).

During this stage, it is important for the second group process goal to be achieved. The therapist must help the clients work through the conflict, anxiety, and confrontation so that the group can move to deeper levels of interaction (Hanson et al., 1980). Corey (1981) has identified some interventions which therapists can make to help clients accomplish this. Some of these interventions are to teach clients the importance of recognizing and expressing their anxieties and the ways in which they react defensively; notice signs of resistance and communicate to the clients that some of these resistances are natural and healthy; teach clients the value of recognizing and dealing openly with the conflicts that occur in the group; point out struggles for control and encourage clients to share responsibility for the direction of the group; provide a model for the clients by dealing directly and honestly with any challenges or acts of hostility directed at the therapist.

During this stage, it is also important for work to begin on the second metagoal described earlier. That is, the therapist needs to help the clients begin working through the psychological and emotional problems underlying their abnormal eating/weight control behaviors. A number of key issues which the therapist will need to help the clients explore are success, loneliness, competition, safety mechanisms, the history of food in clients lives and purposes it serves for them, ability to receive care, control, perfectionism, inadequacy, low self-esteem, self-distrust, self-criticism, all-or-nothing thinking, adult roles, intimacy, and separating from parents (see Anderson, 1983; Bruch, 1978; Garner & Bemis, 1982; Garner et al., 1982; and Levenkron, 1982 for detailed discussions

about these issues as they affect clients with anorexia nervosa and bulimia).

Stage Three

The third stage of group development has been referred to as the development of group cohesion/open exchange of relevant interpretations stage (Tuckman, 1965). During this stage, group cohesion develops and clients continue to explore issues related to their psychological and emotional problems. It is desirable during this stage that a large proportion of the interaction which takes place is of the type found in quadrant four of the Hill Interaction Matrix (Hill, 1965). Interaction in quadrant four is about a client or about the relationship between two or more clients and takes place in a personal, open, and confrontive manner (Anderson, 1984). If this type of interaction takes place, therapeutic work occurs.

Some interventions the therapist can make during this stage to facilitate this type of interaction, to help clients work through their underlying psychological problems, and to help them overcome their abnormal eating control behaviors are:

1. Model and reinforce the appropriate use of behaviors such as self-disclosure, giving and receiving feedback, confrontation, risk-taking, empathic listening and responding, owning thoughts and feelings, concreteness, immediacy, and problem solving. The appropriate use of such behaviors by the therapist and clients promotes group cohesion and therapeutic self-exploration.

2. As clients self-explore, utilize cognitive-behavioral methods formulated by Beck (1976) to help clients identify, challenge, and modify the irrational, dysfunctional thoughts and assumptions which contribute to and maintain their disorders. Such an intervention is proposed because it is assumed, as Garner and Bemis (1982) suggested, that "no matter what course is embarked upon, all therapeutic endeavors will eventually run aground on the fundamental anorexic [and bulimic] premise that thinness is a value of inestimable worth" (p. 128). If this maladaptive premise and the irrational, dysfunctional thoughts associated with it are not modified, it is believed that therapy can't be fully effective with anorexic and bulimic clients. Garner and Bemis (1982) have described in detail how cognitive-behavioral theory and techniques can by utilized to treat anorexia and bulimia. Techniques they have described, such as operationalizing beliefs, decentering, evaluating automatic thoughts, hypothesis testing, reinterpreting, and identifying and modifying underlying assumptions can be used by the therapist.
3. Teach clients self-control techniques and strategies such as setting behavioral standards, self-reward, self-monitoring, stimulus control, self-instruction, affect manipulation, cognitively transforming temptations, self-distraction, restatement of contingencies, covert sensitization, covert modeling (Kanfer, 1980; Thoresen & Mahoney, 1974). Clients should be taught self-control strategies because it is believed that the clients problematic eating control behaviors

(especially binging and vomiting) are habitual and will be difficult to overcome even when the underlying psychological problems are worked through. There is considerable evidence which suggests that clients with bulimia nervosa and bulimia have impulse-control deficits (Goodsitt, 1983; Mitchell & Pyle, 1982). Self-control techniques and strategies, therefore, should be taught to help clients overcome their impulse-control difficulties.

Finally, it should be mentioned that the three stages of group development which have been described and the therapist roles and interventions which take place during them will not necessarily occur in a simple, linear time sequence. Rather, the group is likely to progress cyclically through the stages (Runkel, Lawrence, Oldfield, & Clark, 1971).

Conclusions

It needs to be emphasized and acknowledged that the group treatment plan just described is, as it has been called, a "proposed" treatment plan. The complete treatment package as described has not yet been used in a clinical setting nor have any empirical tests of its effectiveness been conducted. However, the approach is heavily grounded in current theorizing and research about anorexia nervosa and bulimia and is a selective integration of a number of the most promising treatment approaches currently being utilized to treat these disorders. Given the scarcity of group therapy approaches for anorexia and bulimia described in the literature (Bemis, 1978; Schlesier-Stropp, 1984) and the need for

outpatient group approaches to be utilized more frequently (Leon & Phelan, in press), this synthesis seems useful. It provides an alternative to the "foodaholics" group approach described by Stoltz (1984). It is hoped that this multidimensional group therapy approach will be utilized, empirically evaluated, and thereby refined and improved so that as group therapists we can become more effective in our work with clients who have anorexia nervosa, bulimia nervosa, and bulimia.

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